Analysis of HFS-contracted MCO Claims Processing and Payment Performance

For services in Q1 and Q2 of CY 2021

Illinois Department of Healthcare and Family Services

JB Pritzker, Governor
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Introduction

Section 5-30.1 of Public Act 100-0580[1] amends the Public Aid Code to require Healthcare and Family Services (HFS) to "post an analysis of [Managed Care Organization, or] MCO claims processing and payment performance on its website every 6 months." The required analysis mandates a review and evaluation of hospital claims that are rejected and denied, the top 5 reasons for such actions, and timeliness of claims adjudication (focusing upon 30, 60, 90, and 90+ day timeframes). This report is being posted pursuant to Public Act 100-0580.

Date Span of Data

The data provided in this report covers Quarter1 (Q1), or the dates January 1, 2021 through March 31, 2021, and Quarter 2 (Q2), or the dates April 1, 2021 through June 30, 2021, of calendar year 2021.

Data Inclusions and Exclusions

The data analyzed in this report focuses solely on institutional hospital claims, or claims submitted via 837I, or its paper variant (UB04), by hospitals. This means that all other claim types, including professional claims submitted via 837P, or its paper variant (CMS-1500), by hospitals and all other providers, are not included in this report. Professional claims billed by hospitals were excluded as they are processed and often paid in a different manner than institutional claims which makes aggregating the claims potentially misleading. In addition to these professional claims, adjustments were held back from this reporting period. Adjustments can complicate processing periods and reimbursement methodologies and can be triggered for various technical reasons, as such it was determined that adjustments should be set aside until common ground in the data between plans could be established.

Representative Sample.

This report seeks to review all MCO inpatient hospitalization data in whole, establishing the entire data set as the representative sample.

Notes.

1. All dollar values provided in this report have been rounded to the nearest thousand-dollar value.
2. Regarding Charges Billed – Hospitals independently develop the values submitted on their claim as Charges Billed. Billed charges may be significantly higher than the allowable payments negotiated between payers and hospital.
3. Reimbursements detailed in this report do not include all payments made to hospitals under the Illinois Medicaid Program, as it excludes both fee-for-service payments made by HFS and other payments made as a result of the hospital assessment program.

Data Collection Process

The data for this report was collected via Microsoft Excel in a standardized spreadsheet format established by the OMI. The spreadsheet format was disseminated by HFS on behalf of the OMI to all MCOs, and the data was submitted by the MCOs by early May 2022.

All data in this report is provided via self-report from the MCOs. While the OMI seeks to provide data in the most accurate manner possible, data integrity errors may exist in this report related to discrepancies in the interpretation of instructions, variance in health plan data management, and the general potential for human error.

[1] See: http://www.ilga.gov/legislation/publicacts/100/100-0580.htm

Section 1. General Data

Unique Services and Denial Rate

To determine the rate at which hospital claims were being rejected or denied, the number of "unique services" was used instead of the raw volume of claims submitted to MCOs for payment. This was done because multiple claims can be submitted for one discrete service, or hospital stay. Counting unique services in effect removes duplicate claims. For example, if a provider were to submit a claim three times, each time receiving a denial for the same inpatient stay, that service under this methodology would be counted as a single denial. Additionally, given this same example, if a fourth claim submitted by the provider was paid, that service would be counted as a paid claim and not a denied claim, under this methodology – regardless of the three claims denials that occurred, leading to the service reimbursement. Tables 1A and 1B below show how many services were paid, denied, or rejected, and the associated dollar amounts for Quarters 1 and 2, respectively.

Table 1A. Unique Services. 2021 Q1

2021 Q1	Unique Service Count	% of Services	Charges billed	Amount Paid
Unique Services Submitted	1,473,010	100.00%	$8,967,565,000	$1,046,548,000
Payable/Paid Unique Services	1,284,129	87.18%	$7,090,429,000	$1,046,548,000
Rejected Unique Services	65,801	4.47%	$646,335,000	
Denied Unique Services	146,258	9.93%	$1,427,993,000	
Total Non-Payable (Denied + Rejected)	212,059	14.40%	$2,074,328,000	

Table 1B. Unique Services. 2021 Q2

2021 Q2	Unique Service Count	% of Services	Charges billed	Amount Paid
Unique Services Submitted	1,630,694	100.00%	$9,510,392,000	$1,167,980,000
Payable/Paid Unique Services	1,449,145	88.87%	$7,705,393,000	$1,167,980,000
Rejected Unique Services	42,642	2.61%	$388,093,000	
Denied Unique Services	153,341	9.40%	$1,522,195,000	
Total Non-Payable (Denied + Rejected)	195,983	12.02%	$1,910,288,000	

14.4% and 12.0% of unique services submitted for Q1 and Q2, respectively, were either rejected or denied.

Submissions Before Positive Adjudication

Table 2 focuses on efficiency in the claiming process. Providers have the ability to submit unpayable claims multiple times in order to achieve an adjudication determination. Additionally, claims that are negatively adjudicated due to missing or wrong information can be updated and resubmitted for re-adjudication. This table groups positively adjudicated claims by the number of submissions needed for that positive adjudication.

Table 2A. Number of Submissions Before Positive Adjudication 2021 Quarter 1

2021 Q1	Number of Claims	Percent of Claims	Net Liability
1st Submission	1,251,299	94.06%	$911,629,000
2nd Submission	65,398	4.92%	$125,140,000
3rd Submission	6,635	0.50%	$20,201,000
4th Submission	748	0.06%	$4,465,000
5th or More Submission	6,242	0.47%	$8,140,000
Total	1,330,322	100.00%	$1,069,575,000

Table 2B. Number of Submissions Before Positive Adjudication 2021 Quarter 2

2021 Q2	Number of Claims	Percent of Claims	Net Liability
1st Submission	1,372,421	94.30%	$1,043,478,000
2nd Submission	46,992	3.23%	$71,112,000
3rd Submission	8,736	0.60%	$16,082,000
4th Submission	5,278	0.36%	$4,420,000
5th or More Submission	21,885	1.50%	$37,043,000
Total	1,455,312	100.00%	$1,172,135,000

With approximately 6% of claims being submitted two or more times before being reimbursed in the 2 quarters, the data suggests that the current state of hospital claiming across the MCOs is efficient. By efficient, it is meant that paid claims are usually paid upon first submission; no conclusions can be drawn about rejections or denials from these tables.

Timeframe of Claim Adjudication

Table 3 highlights the length of time it takes for claims, following submission, to be adjudicated by the MCOs.

Table 3A. Days for Claims to be Adjudicated
2021 Quarter 1

2021 Q1	Claims	% of Claims	# of Payable/ Paid Claims	Net Liability	# of Non-Payable *	Charges Billed for Non-Payable*
Total Claims Adjudicated in 0-30 days	1,513,473	97.62%	1,301,193	$979,211,000	212,280	$2,108,738,000
Total Claims Adjudicated in 31-60 days	21,823	1.41%	16,634	$57,017,000	5,189	$156,276,000
Total Claims Adjudicated in 61-90 days	4,663	0.30%	3,663	$6,826,000	1,000	$21,188,000
Total Claims Adjudicated in 91+ days	10,472	0.68%	8,834	$26,538,000	1,638	$28,700,000
Total Claims Awaiting Adjudication	1,206					
Total Claims Adjudicated for DOS for Reporting Period	1,550,431	100.00%	1,330,324	$1,069,592,000	220,107	$2,314,902,000

* Non-Payable means rejected or denied.

Table 3B. Days for Claims to be Adjudicated 2021 Quarter 2						
2021 Q2	**Claims**	**% of Claims**	**# of Payable/ Paid Claims**	**Net Liability**	**# of Non-Payable ***	**Charges Billed for Non-Payable***
Total Claims Adjudicated in 0-30 days	1,615,775	97.56%	1,425,896	$1,088,600,000	189,879	$1,767,270,000
Total Claims Adjudicated in 31-60 days	30,438	1.84%	23,645	$63,513,000	6,793	$157,068,000
Total Claims Adjudicated in 61-90 days	3,134	0.19%	1,609	$7,636,000	1,525	$52,357,000
Total Claims Adjudicated in 91+ days	6,699	0.40%	4,163	$12,391,000	2,536	$42,474,000
Total Claims Awaiting Adjudication	5,354					
Total Claims Adjudicated for DOS for Reporting Period	1,656,126	100.00%	1,455,313	$1,172,140,000	200,733	2,019,170,000
* Non-Payable means rejected or denied.						

The data in Table shows that in both Q1 and Q2 approximately 98% of claims were adjudicated within 30 days.

Note. *Table 3 transitions away from reviewing unique services, as detailed in Table 1 and focuses on total claim volume, as such totals between Table 1 and Table 3 will not match. Additionally, given the nature of "usual and customary charges," the non-payable value should not be viewed as an exact or estimated amount owed or lost.*

Adjudication to Payment

Table 4 focuses on the release of money from the MCOs to the provider, following the adjudication of the hospital claim.

Table 4A. Time from Adjudication to Payment
2021 Quarter 1

2021 Q1	Number of Hospital Claims Paid	Percent of Hospital Claims Paid	Total Net Liability for Positively Adjudicated Hospital Claims
Timeframe of Payment to Provider Following Positive Adjudication (0-30 days)	1,229,263	92.41%	$981,794,000
Timeframe of Payment to Provider Following Positive Adjudication (31-60 days)	89,473	6.73%	$82,561,000
Timeframe of Payment to Provider Following Positive Adjudication (61-90 days)	10,798	0.81%	$4,176,000
Timeframe of Payment to Provider Following Positive Adjudication (91+ days)	692	0.05%	$866,000
Total Payments Pending to Provider Following Positive Adjudication	98		$195,000
Total Payments Following Positive Adjudication (Doesn't include pending)	1,330,226	100.00%	$1,069,397,000

Data for Quarter 2 is shown on the following page.

Table 4B. Time from Adjudication to Payment 2021 Quarter 2			
2021 Q2	**Number of Hospital Claims Paid**	**Percent of Hospital Claims Paid**	**Total Net Liability for Positively Adjudicated Hospital Claims**
Timeframe of Payment to Provider Following Positive Adjudication (0-30 days)	1,358,909	93.38%	$1,086,567,000
Timeframe of Payment to Provider Following Positive Adjudication (31-60 days)	94,567	6.50%	$83,185,000
Timeframe of Payment to Provider Following Positive Adjudication (61-90 days)	1,106	0.08%	$760,000
Timeframe of Payment to Provider Following Positive Adjudication (91+ days)	599	0.04%	$837,000
Total Payments Pending to Provider Following Positive Adjudication	111		$360,000
Total Payments Following Positive Adjudication (Doesn't include pending)	1,455,181	100.00%	$1,171,349,000

Table 4 shows that approximately 93% of payments to hospitals from MCOs were made within 30 days of claims adjudication for both Q1 and Q2 (92.4% in Q1, 93.4% in Q2).

Submission to Payment

Table 5: Interval -release of money from the MCOs to the provider, following submission of the hospital claim.

Table 5A. Time from Submission to Payment 2021 Quarter 1			
2021 Q1	**Number of Hospital Claims Paid**	**Percent of Hospital Claims Paid**	**Total Net Liability for Positively Adjudicated Hospital Claims**
Timeframe of Payment to Provider Following Submission of Claim (0-30 days)	1,182,727	88.91%	$829,521,000
Timeframe of Payment to Provider Following Submission of Claim (31-60 days)	117,405	8.83%	$182,443,000
Timeframe of Payment to Provider Following Submission of Claim (61-90 days)	20,509	1.54%	$30,024,000
Timeframe of Payment to Provider Following Submission of Claim (91+ days)	9,585	0.72%	$27,408,000
Total Payments Pending to Provider Following Positive Adjudication	98	NA	$195,000
Total (Not including Pending)	1,330,226	100.00%	$1,069,396,000

Data for Q2 is shown on the next page.

Table 5B. Time from Submission to Payment 2021 Quarter 2			
2021 Q2	**Number of Hospital Claims Paid**	**Percent of Hospital Claims Paid**	**Total Net Liability for Positively Adjudicated Hospital Claims**
Timeframe of Payment to Provider Following Submission of Claim (0-30 days)	1,301,373	89.43%	$916,695,000
Timeframe of Payment to Provider Following Submission of Claim (31-60 days)	145,005	9.96%	$232,145,000
Timeframe of Payment to Provider Following Submission of Claim (61-90 days)	4,131	0.28%	$9,668,000
Timeframe of Payment to Provider Following Submission of Claim (91+ days)	4,672	0.32%	$12,841,000
Total Payments Pending to Provider Following Positive Adjudication	111		$360,000
Total (Not including Pending)	1,455,181	100.00%	$1,171,349,000

Table 5 demonstrates that in both Q1 and Q2 over 98% of payments to hospitals from MCOs were made within 60 days of claim submission (97.7% in Q1 and 99.4% in Q2).

Section 2. Rejections and Denials

Rejected Claims

A rejected claim is one in which the determination of payment cannot be made. These claims may enter the MCOs clearinghouse (front-end) but do not get passed on to the health plan's billing system for payment processing and adjudication (back-end) due to missing administrative elements on the claim. In most cases, the provider may address the issue causing the rejection and re-submit the claim for processing. Table 7describes only the top ten codes, thus the percentages shown do not equal 100%.

Claim Adjustment Reason Code (CARC) Rejections

To gain common understanding across MCOs, hospital rejections by CARCs were collected and measured. Though each of the plans may map and utilize CARCs in a slightly different manner, the top 10 CARC code rejection reasons are provided in Table 6.

Table 6A. Top 10 CARC Rejections 2021 Quarter 1

CARC Code	CARC Code Description	Total Claims	Percent of Claims Rejected
16	Claim/service lacks information or has submission/billing error(s).	19,675	58.35%
96	Non-covered charge(s).	8,013	23.76%
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	3,827	11.35%
18	Exact duplicate claim/service	3,416	10.13%
23	The impact of prior payer(s) adjudication including payments and/or adjustments.	2,852	8.46%
204	This service/equipment/drug is not covered under the patient's current benefit plan	2,563	7.60%
49	This is a non-covered service because it is a routine/preventive exam, or a diagnostic/screening procedure done in conjunction with a routine/preventive exam.	2,200	6.52%
31	Patient cannot be identified as our insured.	2,098	6.22%
27	Expenses incurred after coverage terminated.	1,653	4.90%
208	National Provider Identifier - Not matched.	1,390	4.12%
	Total Rejections (Duplicative)	33,719	

Table 6B. Top 10 CARC Rejections 2021 Quarter 2			
CARC Code	**CARC Code Description**	**Total Claims**	**Percent of Claims Rejected**
96	Non-covered charge(s).	6,342	16.12%
16	Claim/service lacks information or has submission/billing error(s).	4,901	12.45%
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	4,797	12.19%
208	National Provider Identifier - Not matched.	4,031	10.24%
23	The impact of prior payer(s) adjudication including payments and/or adjustments.	3,289	8.36%
18	Exact duplicate claim/service	3,075	7.81%
204	This service/equipment/drug is not covered under the patient's current benefit plan	2,750	6.99%
31	Patient cannot be identified as our insured.	2,216	5.63%
49	This is a non-covered service because it is a routine/preventive exam, or a diagnostic/screening procedure done in conjunction with a routine/preventive exam.	1,710	4.35%
27	Expenses incurred after coverage terminated.	1,538	3.91%
	Total Rejections (Duplicative)	39,351	

Note. *While CARC and RARC codes are standardized, the manner in which a payer chooses to map CARCs and RARCs to their internal Explanation of Benefits (EOB), or proprietary coding can be nuanced, resulting in a difference in application or usage between plans.*

Remittance Advice Remark Code (RARC) Rejections

To gain common understanding across MCOs, hospital rejections by RARCs were collected and measured for the first time. Though each of the plans may map and utilize RARCs in a slightly different manner, the top 10 RARC code rejection reasons are provided in Table 7. RARCs provide additional information regarding claim action and may or may not be present on all claims. Table 7 describes only the top ten codes, thus the percentages shown do not equal 100%.

Table 7A. Top 10 RARC Rejections 2021 Quarter 1

RARC Code	Code Description	Total Rejections	Percent of Claims Rejected
M56	Missing/incomplete/invalid payer identifier.	19,064	57.84%
N/A	(None/Invalid code reported by MCO)	10,256	31.12%
M86	Service denied because payment already made for same/similar procedure within set time frame.	7,933	24.07%
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	7,026	21.32%
N30	Patient ineligible for this service.	3,762	11.41%
N253	Missing/incomplete/invalid attending provider primary identifier.	944	2.86%
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	442	1.34%
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	429	1.30%
N286	Missing/incomplete/invalid referring provider primary identifier.	243	0.74%
N514	Consult plan benefit documents/guidelines for information about restrictions for this service.	236	0.72%
	Total Rejections (Duplicative)	32,958	

Table 7B. Top 10 RARC Rejections 2021 Quarter 2			
RARC Code	**Code Description**	**Total Rejections**	**Percent of Claims Rejected**
M86	Service denied because payment already made for same/similar procedure within set time frame.	6,238	19.43%
N/A	(None/Invalid code reported by MCO)	5,948	18.53%
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	5,392	16.80%
M56	Missing/incomplete/invalid payer identifier.	4,437	13.82%
N30	Patient ineligible for this service.	3,943	12.28%
N253	Missing/incomplete/invalid attending provider primary identifier.	2,989	9.31%
N286	Missing/incomplete/invalid referring provider primary identifier.	678	2.11%
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	365	1.14%
N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	364	1.13%
N238	Incomplete/invalid physician certified plan of care.	224	0.70%
	Total Rejections (Duplicative)	32,104	

While the rejection reasons are varied, the data in the table demonstrates that most rejections are related to technical claiming issues (e.g., missing information, incomplete data, taxonomy issues, plan guideline issues, claim format, payee data, etc.).

Note. *The "None/ Invalid code reported by MCO" line in table 7A means either the rejection reason did not have a RARC associated with it (not all rejections need additional information in the form of a RARC) or the code provided by the MCO was invalid data.*

Denied Claims

A denied claim is a claim submitted by a provider that is not rejected by the clearinghouse but is adversely adjudicated by an MCO based upon one of seven defined HFS denial reason codes. These claims are HIPAA compliant and are fully processed by the MCO claims system but may be denied for payment due to enforcement of payer defined policies. These denials are typically due to the Provider not meeting payer policy requirements around prior authorization, documentation, timeliness, benefits, a service limitation, contractual issue, or other non-contracted provider related issue.

Top Denial Reasons

Denial reasons were reported using CARCs and RARCs, as well as the seven HFS-approved denial codes. The seven denial code categories were created for MCOs to use when submitting encounter data to HFS. Table 8 focuses on denials grouped by denial reason code.

Table 8A. HFS Denial Reasons
2021 Quarter 1

Denial Reason	Number of Claims Denied	Percent of Claims Denied
Timely Filing	10,987	7.76%
Additional Information	36,413	25.72%
Authorization	14,676	10.36%
Benefit / Covered Service	64,328	45.43%
Medical Necessity	-	0.00%
Pre-Certification	5,740	4.05%
Provider	9,455	6.68%
Total Denials	141,599	100.00%

Note: Data for Quarter 2 is shown on the next page.

Table 8B. HFS Denial Reasons 2021 Quarter 2		
Denial Reason	**# Claims Denied**	**Percent of Claims Denied**
Timely Filing	8,900	5.83%
Additional Information	44,798	29.34%
Authorization	14,875	9.74%
Benefit / Covered Service	55,299	36.22%
Medical Necessity	-	0.00%
Pre-Certification	4,360	2.86%
Provider	24,446	16.01%
Total Denials	152,678	100.00%

Across quarters, "Benefit / Covered Service" continues to be the primary denial reason code followed by issues related to "Additional Information", "Authorization" and "Provider". "Medical Necessity" of services continues to be a non-factor with respect to denials, for services that do not require prior authorization or additional information.

Claim Adjustment Reason Code (CARC) Denials

In an effort to gain common understanding across MCOs, hospital denials by CARCs were collected and measured for the first time. Though each of the plans may map and utilize CARCs in a slightly different manner, the top 10 CARC code denial reasons are provided in Table 9. As only the top 10 reasons are shown, the percentages do not equal 100%.

Table 9A. Top 10 CARC Denials 2021 Quarter 1

CARC Code	CARC Code Description	Total Claims Denied	Percent of Claims Denied
96	Non-covered charge(s).	36,018	19.77%
197	Precertification/authorization/notification/pre-treatment absent.	17,141	9.41%
N/A	(None/Invalid code reported by MCO)	12,504	6.86%
27	Expenses incurred after coverage terminated.	10,990	6.03%
29	The time limit for filing has expired.	10,788	5.92%
A1	Claim/Service denied.	10,139	5.56%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	9,392	5.15%
31	Patient cannot be identified as our insured.	8,233	4.52%
16	Claim/service lacks information or has submission/billing error(s).	7,976	4.38%
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	6,370	3.50%
	Total Denials (Duplicative)	182,214	

Table 9B. Top 10 CARC Denials 2021 Quarter 2			
CARC Code	**CARC Code Description**	**Total Claims denied**	**Percent of Claims Denied**
96	Non-covered charge(s).	42,608	21.33%
197	Precertification/authorization/notification/pre-treatment absent.	15,543	7.78%
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	13,601	6.81%
N/A	(None/Invalid code reported by MCO)	10,883	5.45%
18	Exact duplicate claim/service	9,268	4.64%
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	9,235	4.62%
A1	Claim/Service denied.	8,825	4.42%
29	The time limit for filing has expired.	8,728	4.37%
31	Patient cannot be identified as our insured.	7,896	3.95%
16	Claim/service lacks information or has submission/billing error(s).	7,891	3.95%
	Total Denials (Duplicative)	199,723	

Overall, the CARC denial detail in Tables 9A and 9B compliment and expand on the information found in Tables 8A and 8B. While the primary denial reason is related to non-covered charges, most other codes detail procedural issues (precertification, benefit covered in another service, time limit for filing has expired, charge exceeds fee schedule, service not covered, etc.) providers are struggling to meet in accordance with plan requirements.

Remittance Advice Remark Code (RARC) Denials

In an effort to gain common understanding across MCOs, hospital denials by RARCs were collected and measured for the first time. Though each of the plans may map and utilize CARCs in a slightly different manner, the top 10 RARC code denial reasons are provided in Table 10. As only the top 10 reasons are shown, the percentages do not equal 100%.

Table 10A. Top 10 RARC Denials 2021 Quarter 1

RARC Code	Description	Total Claims Denied	Percent of Claims Denied
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	30,898	25.87%
N/A	(None/Invalid code reported by MCO)	24,358	20.40%
M86	Service denied because payment already made for same/similar procedure within set time frame.	7,347	6.15%
M62	Missing/incomplete/invalid treatment authorization code.	5,203	4.36%
M56	Missing/incomplete/invalid payer identifier.	4,850	4.06%
N238	Incomplete/invalid physician certified plan of care.	4,619	3.87%
M50	Missing/incomplete/invalid revenue code(s).	3,790	3.17%
M67	Missing/incomplete/invalid other procedure code(s).	2,756	2.31%
N23	Alert: Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions.	2,613	2.19%
N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.	2,464	2.06%
	Total Denials (Duplicative)	119,431	

Table 10B. Top 10 RARC Denials 2021 Quarter 2			
RARC Code	**Description**	**Total Claims Denied**	**Percent of Claims Denied**
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	38,503	30.22%
N/A	(None/Invalid code reported by MCO)	19,147	15.03%
N238	Incomplete/invalid physician certified plan of care.	9,219	7.24%
M62	Missing/incomplete/invalid treatment authorization code.	7,251	5.69%
M86	Service denied because payment already made for same/similar procedure within set time frame.	6,640	5.21%
M50	Missing/incomplete/invalid revenue code(s).	4,797	3.77%
N479	Missing Explanation of Benefits	2,808	2.20%
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	2,779	2.18%
N19	Procedure code incidental to primary procedure.	2,273	1.78%
MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	2,253	1.77%
	Total Denials (Duplicative)	127,390	

The data in Table 10A and 10B demonstrate that the HFS-contracted MCOs are relying heavily upon proprietary remittance advice coding or single-level CARC coding in their messaging to providers on denials, with 20.40% of denials in Q1 and 15.03% of denials in Q2 being attributed to “None / Invalid Code” used by MCOs.

Conclusion

There was an 87.2% clearance rate of hospital claims reported against $1,047M in payable claims in Q1. The clearance rate increase to 88.9% in Q2 against $1,168M in payables. Additionally, approximately 94% of hospital services in Q1 and 94% in Q2 are being adjudicated by HFS' MCOs upon first submission, another strong metric of efficiency. Note that these numbers are basically unchanged compared to Q3 and Q4 of 2020.

From a financial perspective, hospital claiming from MCOs can be qualified as ***generally paying hospitals within 60 days of claims submission***. This characterization is supported by approximately 98% of claims in Q1 and 98% of claims in Q2 being adjudicated within 30 days of submission from a provider. These were followed by approximately 93% of adjudicated claims in both Q1 (92.4%) and Q2 of (93.4%) resulting in actual payment to providers within 30 days. In totality, approximately 89% of payable claims in Q1 and Q2 (88.9% and 89.4% respectively) are adjudicated and paid to providers within 60 days of submission. However, it must be noted that by this same standard, pursuant to 305 ILCS 5/5-30.1. Managed Care Protections, sub-section (g), about 10% of claims in Q1 and about 10.6% of claims in Q2 would be eligible for interest from MCOs, as they were not adjudicated and paid to the provider within 30 days of submission. As in the prior 3 previous reports, it is noted that data from one health plan, CountyCare, is impacting the overall performance statistics of MCOs regarding timely payment of claims. For Q1 and Q2 of 2021, if CountyCare's claims data are excluded from the analysis, the percentage of claims paid within 30 days of submission would increase to 97.7% in Q1 and 98.0% in Q2, compared to the actual percentages of 88.9% in Q1 and 89.4% in Q2. However, CountyCare's claims payment timeliness has notably improved from Q3 and Q4 of 2020. The percentage of claims paid within 30 days increased from approximately 27% in the Q3 and Q4 2022 period to 35% in Q1 2021 and 37% in Q2 2021. The percentage of claims paid within 61 to 90 days has greatly increased, from 13% to 55% for Q1 and from 15% to 61% for Q2 2021. But County Care continues to lag significantly behind the behind the performance of other MCOs in terms of the percentage of claims paid within 30 days of submission.

As with previous reports, CARCs and RARCs continue to be collected. However, each plan's use of CARCs and RARCs has its own nuances. While the inclusion of CARCs and RARCs provide additional detail, a crosswalk between plans would provide a better understand each plan's payment processes.

HFS 'Efforts to Improve Communications and Support:

To help improve communication between all providers and the MCOs, the Department continues to work with MCOs and providers.

- HFS has worked with each MCO to connect them to the ACE system, an electronic claims processing environment that all MCO claims flow through to give HFS insight into the details of all claims and MCO responses. The system allows HFS to begin to distinguish and quantify issues that are billing errors by providers, those that are legitimate denials by the MCOs and those that are improper rejections or denials by the MCOs. At this time all MCOs are connected to the ACE system and claims and responses are in the process of being collected in the system and sent to the HFS Data Warehouse. HFS is also beginning to analyze the data to identify issues in billing and claim adjudication.

- HFS continues to conduct monthly meetings between providers and MCOs to improve communication and address policy and procedural issues, including discussion on provider rejections and denials. Significant payments to providers have come as a result of reprocessed claims following system corrections in response to these meetings.

Office of Medicaid Innovation

This report was prepared by the Office of Medicaid Innovation (OMI) at the request of Department of Healthcare and Family Services (HFS).

The OMI is a specialty unit within the University of Illinois System that seeks to utilize U of I resources from across all of its campuses to provide administrative, clinical, and operational support to HFS in the administration of the Illinois Medical Assistance Program.

The OMI can be contacted at:

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Definitions:

Adjudicated Claim: A claim that has been processed by the MCO or its vendor, and a determination as to whether or not that claim is payable has been made. Claims that have been Rejected or Denied, or have been determined Payable, or that have been paid, are all adjudicated Claims.

Claim Adjustment Reason Code (CARC): A HIPAA mandated code set to be used in an Electronic Remittance Advice explaining why an action was taken on a claim.

Date of Submission: This is the date that a claim, paper or electronic, is received by either the MCO or their agent (i.e., EDI clearinghouse).

Denied/Denied Claim: A claim where the payment was denied by the MCO to a Provider corresponding to HFS defined administrative reasons/codes. These claims are HIPAA compliant and may be fully processed by the MCO claims system but are denied for payment due to enforcement of payer defined policies. These denials are typically due to the Provider not meeting payer policy requirements around prior authorization, documentation, timeliness, benefits, a service limitation, contractual issue and non-contracted Providers. For purposes of this report, MCOs are to report the relative counts into one of the following seven (7) Denial Reasons.

> **Note**: HFS defines denials as denial of payment for a claim for the seven Denial Reasons described in this section of the report, and only these reasons.
> Additional Information: Provider claim is denied because the Provider has failed to supply the required information and the MCO needs the Provider to submit more information to process the claim (i.e., doctor's notes).
>
> *Authorization*: Provider claim is Denied by MCO because Provider did not meet MCO's authorization policy on Provider network status, service limits, medical necessity, non-emergency services, or missing/invalid authorization form/record.
>
> *Benefit/ Covered Service*: Provider claim is denied by MCO because Provider did not meet MCO's policy for Covered Services which are eligible for reimbursement. Note that the MCO may cover some services which are traditionally not covered by HFS as stated under Section 104 of Chapter 100 – Handbook for Providers of Medical Services (https://www.illinois.gov/hfs/SiteCollectionDocuments/100.pdf). If there is TPL benefit for which the MCO Denied coverage, it should be reported as a Benefit/Covered Service denial.
>
> *Medical Necessity*: Provider claim is denied by MCO because Provider did not meet MCO's reimbursement policy for medical necessity.
>
> *Pre-certification*: Provider claim is denied by MCO because Provider did not meet MCO's pre-certification for Hospital and SUPR (formerly DASA) services.
>
> *Provider*: Provider claim is denied by MCO because: 1) Provider is sanctioned by OIG, 2) Provider is not registered with HFS, including Providers who are out-of-state and not registered with HFS, and 3) Provider isn't certified or eligible to be paid for this procedure/service on this date of service. It is expected that Provider works with HFS IMPACT/OIG team to activate their status so

that claims can be reprocessed by MCOs for reimbursement. (In each of these cases, MCOs have decided to reimburse $0 and nothing will change that reimbursement value, until the Provider is enrolled with HFS.)

Timely Filing: Provider claim is denied by MCO because Provider did not meet MCO's timely filing policy, including any waiver period.

Hospital Claims: All claims, billed by a provider who is enrolled with HFS' Medical Programs as a General Hospital (Provider Type 030), Psychiatric Hospital (PT 031), or Rehabilitation Hospital (PT 032). NOTE: Only report Institutional hospital claims are included in this report.

Paid Claim: A claim submitted by a provider to a MCO that has been adjudicated, resulting in reimbursement to the provider.

Payable Claim: A claim submitted by a provider to a MCO that has been adjudicated and determined to be payable.

Rejected/ Rejected Claim: A rejected billing claim is one in which the determination of payment cannot be made. These claims may enter payer claims system (front-end) but do not pass further into adjudication and payment processing (back-end) due to missing administrative elements on the claim. All claims categorized as denied/rejected due to ineligibility, or claims denied/rejected because a duplicate claim has already been paid, as a rejected claim.

Rejected claims are:

1) Claims submitted to an MCO that were accepted through the Electronic Data Interchange (EDI), but subsequently removed/deleted from the adjudication system;

2) Claims that rejected through the EDI translator for failing any SNIP (see definition below) validations; and

3) Any custom business rules implemented in EDI that reject claim submissions.

Examples of missing administrative elements include taxonomy code, value codes, occurrence codes, modifier codes, billed units, covered days, invalid recipient ID, notes, and NDC codes. In most cases, once the administrative element is added and the claim is resubmitted by the Provider to the MCO, the claim may be adjudicated.

Remittance Advice Remark Code (RARC): A HIPAA mandated code set to be used in an Electronic Remittance Advice explaining why an action was taken on a claim. It is used in addition to a CARC. Not all actions require a RARC.

Unique Service: Multiple claims can be submitted for one service. To report Unique Services only report unique combinations of a provider's NPI/ Medicaid ID, patient Recipient ID/ Medicaid ID, admission through discharge date, and bill type. NOTE: For institutional claims, report Unique Services at the claim level of detail.